Building-blocks

Community Health Cell, Bangalore

May 2010

Editorial Note

Dear friends,

'Building Blocks' is an occasional newsletter of the Community Health Learning Programme(CHLP) showcasing the varied experiences of the interns embarking upon their journeys in community health, towards the goal of 'Health for ALL'. The year 2009 saw a batch of eight full time interns and four flexi-time interns. These interns came from different parts of India including North-East, Rajasthan and Maharashtra.

The 2009 batch of interns had a rich diversity of experiences to share and learn from, with backgrounds such as nutrition, basic sciences, public health, political sciences, social work etc. The group itself was also quite a varied mix of languages and backgrounds. The Orientation sessions, field visit to a Dalit Women's Collective, Jagrutha Mahila Sanghatana (JMS) in Raichur district, the field placements and the sharing sessions at regular intervals as usual were the core activities of the 2009 batch. In addition in September 2009 Community Health Cell hosted a course of the International People's Health University titled "Health and Equity" as part of its silver jubilee celebrations. The interns were invited to be a part of this which gave them a great exposure to experiences of work in health by participants and faculty from 15 countries.

This newsletter is an amalgamation of personal experiences, learnings, study findings and policy observations of the CHLP interns, action taken for the areas affected by the floods in northern Karnataka and an update from the functional units of SOCHARA. The main thread that runs through the different articles is the issue of class, caste and gender inequities which often gets sidelined but is more often the root cause of the problem.

The country today is marked by contradictory forces. Whilst the National Rural Health Mission is bringing about a great energization of the health system and people's participation at various levels is clearly on the agenda like never before, an assault on basic livelihoods, access to basic resources and the determinants due to the present model of development is also obvious. Inequity in health and economic statistics is increasing. People are living in dire poverty. The state seems to be increasingly unsure of its response to dissent. The interns of the present batch are entering this field of mixed signals. We do hope that they develop an undying positive and constructive approach. Their articles and submissions featured in this collection certainly show their positive spirit and the various dimensions of understanding the societal realities.

CHC Editorial team

[The content of this newsletter pertains to the period from April 2009 to March 2010.]

Face to face with Repercussions of Caste Inequalities

During the orientation, on 21st May, 2009, the interns were taken on a field trip to Potnal, Manvi Taluka, Raichur district where a Dalit women's organization called Jagrutha Mahila Sangathan works on various livelihood and rights issues. Around six kilometers from Pothnal is a village called Tadkal. This village has a population of over 2000. The social fabric of the village is dotted with diverse communities which include Lingayat, Kurubas, Muslims, Gollaru's, Nayak's, Badiga Chalwadis, Madigas, Oddas, Koravas etc. Among all these, the Madigas belong to the Dalit community who come under the Scheduled Caste Category and have been treated as an untouchable community having no access to common water sources and temples even till today. The Lingayats belong to the dominant community with major landholdings.

For the past few years, the Madigas have been facing oppression from the non-dalits in their village. Around 40 families (now grown into 80 households) in the village belong to the Madiga community. Though discrimination against dalits has been a reality in Tadkal, it never had the shades of violence and hatred.

In May 2008, Tadkal village received funds to build a Sub health centre under the Member of Legislative Assembly's (MLA) Local Area Development Fund. The Gram Panchayat in its general body meeting had unanimously decided and passed a resolution to build the sub centre near the newly demarcated housing colony for the poor, the 'janata colony', about 500 meters away from the village and sufficient land was allotted for the same. The Madigas, due to their long standing demand for housing for several years, were allotted plots of land, on the government land just at the entrance of the village where the main road passes.

But in a total turn of events, maneuvered by few members of the upper caste and allegedly engineered by the land lord of the village(owner of about 200 acres) who had taken the contract to build the sub health centre, shifted the venue from the Janata Colony to the one vacant plot set aside by Madigas for the community hall (Ambedkar Bhavan) in the Madiga Colony. Having no entry to any common facilities like the marriage hall and having only a small house built on a government allotted plot, the community hall would serve as a place for all common activities like death, birth and marriage related ceremonies.

The Madigas made their appeal against such a proposal, and requested the villagers and panchayat not to encroach on their rights in the name of village welfare. But when neither the villagers nor the officials were willing to support them, the Madigas approached the Dalit Movement leaders (DSS), who arrived at the spot expressing their complete support against the upper caste conspiracy to grab Dalit land. The rich land owner belonging to the Lingayat community severely opposed this boldness of the Madigas. The upper castes succeeded in rallying the entire village against the Madigas and branded them as hurdles in the path of Tadkals' development. The Madigas, however, pointed out that the move to construct the health sub-centre in their place was in violation of the gram panchayat resolution itself!

As the demand of the Dalits was building up, on 6th January 2009, in an unexpected move, the gram panchayat called for gram sabha to discuss the construction of the sub centre and approved to shift the construction of sub centre to the site wanted by the landlord (i.e. in the Madiga Colony) amidst severe opposition from the Madigas. A month later, without any prior information, the construction of sub health centre got commissioned in full scale on the proposed plot for the Ambedkar Bhavan. Overnight the foundation was laid and pillars erected. The Madigas protested severely, compelling the police to stop the construction.

Various ways of physical and psychological torments had started by then and continued on Dalits such as on 21st January 2009, when a person from the Madiga community complained to the upper caste hotel owner that the waste water from the hotel was coming into their (Dalit colony) streets and making it difficult to walk, the hotel owner along with his friends thrashed the person from the Madiga community. With the support of other Dalit leaders, the severely wounded person filed a police case against the hotel owner and his friends under the SC/ST (Prevention of Atrocity) Act which led to their arrest.

The refusal to accept the decision of the upper castes and suspension of the construction of Sub health centre was like adding injury to insult. In order to avenge this insult the upper caste community men , who had also instigated men from all non-dalit castes, attacked the Madiga Dalit community with sticks and stones and beat up several men injuring them, damaging the doors, walls and roof (made of asbestos sheets) of their houses. While several Madiga men fled from the scene many who were caught by surprise were injured. This

was done with the intent of terrorizing and compelling them to agree to their demands. Having beaten up the Dalit men and backed by the landlord the upper caste men succeeded in exerting their influence over the police and filed false complaints on the Dalit men. In addition, the upper caste community decided to impose a social boycott on the Madigas.

Social boycott is a community ex-communication where the Madiga community was not allowed to use the auto rickshaw (all of which was owned by the upper castes), were denied access to the flour mill and the eateries. The farmers, carpenters and others were prohibited from employing Madigas for daily wage work. Anyone who violated the boycott had to pay a fine of Rs. 500/-. While the social boycott was a nightmare for women as they had to take jowar to the far away villages for making flour, to buy groceries etc. One woman, while returning from a distant village with jowar flour, fell down from a tractor in which she was traveling (as she was not allowed in the autos) and was hospitalized incurring nearly Rs.6,000 in expenditure.

In the aftermath of this event while the social boycott was still on the CHLP interns paid a visit to this village and sat with them to hear their tale of woes. This incident is a gross violation of the basic human rights. They expressed strong solidarity with the affected community. Many of the interns were quite moved by this experience. To some it led to a deeper personal introspection and reflection:

Interns on tractor going for their field visit in Raichur

"For those who believe caste discrimination is not a persistent reality, know that it currently manifests in the most inhumane and oppressive ways. We express our solidarity in fighting this institutional oppression that continues to cripple the dalit community of Tadkal."

- Bhavya Athmika Reddy

"We feel a strong and urgent need to address this issue and provide the dalit community their social and livelihood rights with dignity, as soon as possible."

- Deeksha Sharma

"Meeting the families and interacting with the villagers made us realize how atrocities are inflicted on people who are less fortunate. This inhumane treatment has left a scar in their hearts. Inspite of this painful incident, the courage and the hope the Madiga commuinty has in fighting against this injustice is truly an inspiration. We join hands in their fight for justice."

- Mary Julie

"Tadkal brought to light the vivid presence of social evils despite our many years of independence and strife towards equality in Indian society. What leaves one feeling hurt by this presence is that it is initiated and supported by the very machinery sworn to uphold the rights and work towards a better quality of life for all in a community. It was a strong reminder that social exclusion remains. There is no helping hand for a dalit in the community. There is nobody she/he can question and trust. At the end of our interaction with the dalits an old man shook hands and thanked us for listening. We thank him for sharing his story with us and hope his community finds strength in awareness and action."

- Malavika Thirukode

"The Tadkal incident of social boycott was a real eye opener. I merely had a notion of how a social boycott is and always thought that the textbooks were an exaggerated version. But the visit made me see the real implications of a social boycott and its consequence which I dare say may be more than what is written in the books."

- Shelley Dhar

Field Realities

"I feel that the practice of casteism and the boycott of people by their own community in the 21st century is inhuman. Society must look at this as a mirror, a reflection of what we are. Oppressing the marginalized community is very easy for the upper class people because they have the support of finance and power. They use political power. People in governance and the media are one sided and do not expose the reality of the situation. The Madiga community of Tadkal is isolated within their own village which is a really pathetic situation. The 'thunder' of class, caste and gender continues to roar in Tadkal. There is an urgent need for engagement to end this conflict. We must engage with people of this community to solve the issue not just for today but forever so that they may finally silence this ominous thunder that threatens Tadkal and similar places."

- Shivakumar N.

[Subsequently CHC led a fact-finding team of Human Rights activists and follow-up was done to support the Dalit community in Tadkal. - Ed.]

View Point

Population Control Conundrum

Since independence in India, fertility reduction has played an obstinate role in government health agendas and budgets. The late 1970s, following the state of emergency, witnessed an extremely coercive population policy that resulted in manifold human rights violations, with poor health and dire social outcomes.

In 1994 at the United Nations' International Conference on Population and Development (ICPD) in Cairo, India was one of 179 countries that promised to promote the reproductive health of women; censuring coercive population policies. In 2000 India furthered its commitment to the ICPD through the inception of the new National Population Policy (NPP), which categorically faults punitive measures to reduce fertility rates; offering a target free approach without incentives and disincentives, with the voluntary and informed choice of citizens; and a focus on maternal and child health.

Omitting these commitments, punitive measures to reduce fertility rates have surfaced once again through the inception of the 'two-child norm' in many states. Studies in Madhya Pradesh, Rajasthan, Andhra Pradesh and Bihar have shown various violations of the NPP and the ICPD. Expulsion of the third child from social welfare schemes (PDS) and even government schools has been reported. In Andhra Pradesh "motivators" of sterilization are bribed with gold chains, in Bihar they're rewarded with arms licenses. Worse still is the rampant disqualification of people (informed or uninformed of the implementation of the two-child norm) from political posts in Panchayati Raj Instituions (PRIs). The deeper repercussions of this punitive measure are outlined below.

Women bear the brunt

A study in 12 districts of Madhya Pradesh (MP) has shown that since the implementation of the two-child norm, in order to retain Panchayat posts, women were forced into unsafe abortions; husbands abandoned wives to denounce responsibility of the third child; female feticide and infanticide was on the rise; and the giving up of children (usually female) for adoption was common. In a country where son preference is still critical to family planning, the enforcement of the two-child norm will only skew the existing, alarmingly disproportionate sex-ratio further, and cause more harm to women in the process.

Ironically, while the abuse of women's basic human rights continue in the name of the two-child norm, great strides are being taken toward a 50 percent reservation for women in PRIs.

Marginalizing the marginalized

With ample evidence linking poverty and fertility, it is explicable that dalits, adivasis and other marginalized communities often experience higher fertility rates- due to poorer access to healthcare, living conditions and information. While there is reservation for Scheduled Castes and Scheduled Tribes (SC/STs)

in Panchayats, the study in MP showed they made up a disproportionately large number of the dismissals (50 percent). It is both unfortunate and illogical that the promotion of inclusion and representation of SC/STs, the basis for reservation, can be so grossly undermined and derailed by another State policy.

Youth loose out

36 percent of India's population is at the prime reproductive age (therefore young) and it is likely that they make up the largest portion of couples conceiving a third child beyond the stipulated date. Denying their political representation at PRIs based on fertility is irrational. The study in MP showed positions vacated by younger representatives were replaced by elders. On the one hand, while efforts are underway to strengthen the National Youth Congress; at the grassroots level, progress to include 'young India' in decision-making is being unravelled by the two-child norm.

Development versus Population control

Kerala and China are both cited as cases of considerable decline in fertility rates; however Kerala did not resort to coercive measures. Today Kerala's total fertility rate has dropped below the national replacement level at 1.9. Investments in health and education brought down maternal and infant mortality, and increased women's access to healthcare and information.

Web Exercise: Understanding Gender

Punitive measures of the two-child norm, such as the disqualification of women, SC/STs and youth from PRI posts, and expulsion from social welfare schemes will only exacerbate the conditions that cause high fertility in the first place. Narrow, targeted approaches to reducing fertility rates without addressing the root causes of high fertility, or complementary action to strengthen reproductive health services have not only failed to reach desired targets but have clearly allowed for human rights violations along the way. High fertility rates are a direct reflection of poor healthcare infrastructure, education, and decision-making power of women; neither can it be addressed in isolation from food, livelihood, employment and all basic forms of social security. Planners of state population policies must pay attention to the causes of high fertility, and address it in ways that are sustainable, democratic and humane.

- Bhavya Athmika Reddy

Reflection

Time spent as a CHLP Intern

It was a brief few months but an opportunity to introspect and learn. Orientation into the sensitivities of the field and travelling put our purpose as interns into perspective. The Community Health Learning Programme(CHLP) is all about perspectives. You begin with one but leave transformed to think practically and importantly, realistically. If you feel disillusioned about ways in which you may help, the leap from blind knowledge to purposeful action through the CHLP would be the best option you could ever choose. You learn from your friends and their experiences. Also, you learn to share and appreciate opinions and views. I learnt to look beyond the surface and prod to find the truth. We are a socialised, often opinionated few with the most opportunities. Hence, it is all the more important to try unchartered territory when given the chance. I took the opportunity to interact with NGOs and budding movements while interning in the CHLP. In doing so met with professionals and volunteers working with marginalised groups such as migrant workers. I realised their lack of identity and began to take notice of the sights and sounds of Bangalore city less heard

and less seen. Towards the last few weeks we worked towards raising awareness on the 'Right to Food' bill on Independence Day. Talking to the youth about the issue and interactions with activists were valuable insights into the shaping of movements, the importance of national policy and the role of people led groups in bringing to notice the need to look into issues in its totality. As an intern you learn and after you learn, spread the message and call on more to open their minds to 'see', not merely 'look'.

- Malavika Thirukode

Field Realities

Widespread Malnutrition: A study to find "Cause of Causes"

India ranks 66th, out of 88 countries, on the 2008 Global Hunger Index (GHI)*. All the Indian states have "serious", with Madhya Pradesh (M.P) having an "extremely alarming", level of hunger. Primarily, this is due to its relatively high levels of child malnutrition and undernourishment resulting from calorie deficient diets. The widespread malnutrition situation despite many ongoing nutrition related government programmes (Table-1) is debatable.

Table-1 Nutrition Related Programmes in India

Direct Nutrition Interventions	Indirect Nutrition Interventions
Ministry of Women and Child Development- • Integrated Child Development Services (ICDS) Scheme. • Nutrition Programme for Adolescent Girls (NPAG)	Food and Public Distribution • Targetted Public Distribution System • Antodaya Anna Yojana • Annapurna Scheme
Ministry of Health and Family Welfare- • Iron & Folic Aci -d Supplementation of pregnant women • Vitamin A supplementation of children of 9-36 months age group. • National Iodine Deficiency Disorders Control Programme	Rural and Urban Development • Food for Work Programme • Poverty Alleviation Programmes • Safe Drinking Water and Sanitation • National Rural Employment Guarantee Scheme
Department of Elementary Education and Literacy- • Mid Day Meal for primary school children	Ministry of Health & Family Welfare • National Rural Health Mission • Integrated Management of Neonatal and Childhood Illnesses (IMNCI)
Department of Agriculture and Cooperation • Increased Food Production • Horticultural Interventions	

To understand implementation of these programmes in the broader socio-economic, political and cultural (SEPC) framework, a micro-study was planned in MP's Sehore District with the help of a local organization, Samarthan. After identification of the programme implementers at district and block level, one village (with representing population of Scheduled Caste and Scheduled Tribe) was chosen to observe service delivery and interact with service providers. At the village level Focus Group Discussions were conducted with mothers group, elderly women, PRI members, adolescent boys and adolescent girls, to know their experience with these programmes and views on how to improve nutrition.

* GHI is calculated using three equally-weighted indicators: the proportion of the population that is calorie deficient, the prevalence of underweight children under the age of five, and the under-five mortality rate. Can be accessed at: http://www.ifpri.org/publication/2008-india-state-hunger-index-key-findings-facts

The major observations and findings of this study with respect to policies, programme implementation and communities' experience are provided below:

I. Programme Policies:

- The issues related to malnutrition are seen as the responsibility of Women and Child Development (WCD) department when there are other departments which are equally responsible for betterment of malnutrition situation.
- Policies don't facilitate change at the beneficiary level as little consideration is given on their participation during policy making.
  - Integrated Child Development Scheme (ICDS): There is too much focus on Supplementary Nutrition Programme (SNP), one among the 6 interventions. Further, policies often take 3-6 yrs olds into consideration when the malnutrition sets in between 6 to 18 months of age. Anganwadi Centres (AWC) does not work as Day-care centers because the closing time is 2 pm. Therefore mothers going for agricultural work leave their children with older siblings or elderly people at home as they return only in the evening.
  - Health: Programmes focus more on Ante-natal Care (ANC) than on Post-natal Care (PNC), resulting in less support and assistance to the mother to practice optimal infant feeding. Also lactating women's increased diet (500 calories) requirements are often ignored, which is even greater than (300 calories) during pregnancy.
  - Mid Day Meal (MDM): Fund allotment of Rs 2.08 + grains per day per child is not enough to follow six days menu with feast on Saturdays & National holidays. Also Self Help Groups (SHGs) have to do atleast a saving of 500 Rs per month, when allotment is not enough to provide quality food to the children.
  - Public Distribution System (PDS): It targets Below Poverty Line (BPL) families but there are issues with identification of BPL families. Also it considers family as the unit for distribution of ration, which cannot be optimal, as some families have fewer members and some have more.
  - National Rural Employment Guarantee Act (NREGA): The wages are given according to work. The criterion is not according to unemployed, disadvantaged population groups and their capacities.

II. Programme Implementation:

- SEPC factors limit access of communities to services and also build constraints to service providers.
  - Caste dynamics: Sometimes the caste of Anganwadi Workers (AWW) and helper come between service provision and utilization. If AWW is from upper caste, she is least accountable to the Scheduled Caste (SC) and Scheduled Tribe (ST) population, however if AWW is from lower caste, upper caste community members do not allow their children to eat the SNP provided by them. As the SNP is the main motivation, this caste dynamics actually effects utilization of other programme components as well.
  - Power Play: It works both in positive and negative terms. In one case Auxiliary Nurse and Midwife (ANM) was not staying in the village as she was the chief minister's relative. The District collector's role was found highly influential in improving “Immunization” coverage and taking initiative for treatment of malnourished children at home by providing “1 egg and 250ml milk” through village panchayat.
  - Gender discrimination: Often gender plays a very intricate role in utilization of services. Education for girls is not a priority which adds to their limited mobility and reduces the chances of getting information and utilization of available services. Mother-in-laws restrict young pregnant and lactating mothers to get SNP from AWC, as the rationale is not provided in clear terms.

- Systemic Constraints:

  1.Human Resource:
  - Lack of supportive supervision: There is lack of supportive supervision to deal with the day to day challenges and implement the intended services in best possible way. For AWWs, supportive supervision by immediate supervisors is the missing link, where AWWs find that their concerns are not listened to and in the long run get demotivated to perform assigned duties.

- Capacity building and motivation: Capacity building and simultaneous motivation are necessary to get desired outputs. However, often it seems that capacity building issues are least thought of before assigning the duties. For example the Sarpanch should be given sufficient training on how to handle NREGA work and make proposals; the SHGs should be trained on how to manage MDM and savings both; the AWWs should be trained on Behaviour Change Communication (BCC) and how to link Nutrition and Health Education (NHED) with Growth monitoring
- Too much administrative work: Often lengthy administrative work takes up most of the time, leaving little time to contribute to actual implementation of the intervention. ANMs and AWWs are supposed to manage 20 registers besides their well defined duties at the center and for outreach. As system puts pressure on reporting through monitoring the actual work in the fields get neglected.

2. Infrastructure: Most AWCs don't have independent building and run from panchayat and school buildings. Lack of proper lighting, ventilation and other basic necessities do not encourage communities to send their children.
3. Lack of planned systemic structure: A clear cut strategy with setting goals to ensure accountability at the end is missing. There is no means to ensure that if this much input is given certain output is expected.

- Inter-sectoral Coordination: ANM, Accredited Social Health Activist (ASHA) and AWW are supposed to work together at village level; however, there is complete lack of joint planning, implementation & monitoring at the higher levels.

III. Communities Experiences:

- Lack of awareness on entitlements and available services: In the communities all 6 interventions of ICDS were not known, though it is running from 1975. There is lack of focus on BCC, where Block Extension Educator (BEE) post is more or less becoming redundant with no new recruitments. Though home visits are included in CDPOs, Supervisors and AWWs job but still it seems more on papers with little focus on capacity building on NHED component.
- General lack of interest in health and food as health is seen as "absence of disease" and not as state of physical, social and emotional wellbeing.
- Effect of Globalization:
  - Displacement of tribal communities has disrupted their livelihood and left them with little food options, as earlier they used to eat different grains and wild fruits.
  - Loss of traditional knowledge and adoption of faulty feeding practices with aggressive marketing of packaged food items like biscuits have now become the common weaning food even in rural areas
  - Cash cropping/ contract farming and increasing food prices has reduced food diversity and availability at rural households
  - Global warming and climate change: with increasing drought and less water availability rural people grow vegetables only in rainy seasons

Way Forward: Advocating & Working with Communities

- Building bridges between policy makers and grassroot communities so that their interests and voices get heard while planning policies
- Creating awareness about entitlements and services available under different nutrition related programmes using VHSC, Mahila mandals, Mother support groups, youth forums etc.
- Bringing empowerment and ensuring community participation in implementation and monitoring of these programmes
- Working for equitable access to services provided under nutrition related programmes by engaging with service providers

- Ultimate goal is to work towards "Food Sovereignty,"** which is the right of people to healthy and culturally appropriate food prod -uced through
  - ecologically sound and sustainable methods
  - their right to define their own food and agriculture systems

Food sovereignty implies new social relations free of oppression and inequality between men and women, peoples, racial groups,social classes and generations.

-Deeksha Sharma

International People's Health University Course on Health and Equity: An intern's experience

The nine day short course on 'Health and Equity' run by the People's Health Movement's (PHM) International Public Health University (IPHU) in Bangalore was a rare experience for many reasons. Firstly it was an opportunity to meet and network with 'health for all' activists- veterans and novices alike, from around the country and the globe. As a novice I was able to understand the history of PHM, the events leading up to its inception, and how it has grown in number and spread to many new countries. This conveyed a sense of national and global solidarity, which was new and exciting to me.

Below I outline the major lessons I took away from the IPHU:

- The role of PHM, how it works

Before the IPHU I did not fully understand what the PHM is- an organisation, a network, a movement? I'm now comfortable with the concept of it being a combination of all these, and as Prof. David Legge put it, 'an organisation of network of networks'.

The alliances that the PHM enables are on all levels, from local to global. Each level has the ability to link with the next level and so on, ultimately leading several countries both in the developing and developed world, to fight global deterrents to equity in health.

- Globalisation is central to the PHM discourse

A major thrust of PHM's efforts is to fight the negative processes and outcomes of globalisation. The current neo-liberal economic order is heavily critiqued for promoting the unequal distribution of wealth, which enables inequity in health. Plainly put the expansion of the market economy into the health sector, as described in the IPHU course, has led to 'private insurance for the rich, social insurance for the middle class and a safety net for the poor'.

Concepts introduced by Amit Sen Gupta, such as speculative capital and how it impacts the health sector were new to me, and which I found stimulating.

The IPHU also threw light on the positives of globalisation. The networks the PHM helps form shows how globalisation can take place from below through solidarity at a local level and intervention at an international level.

- Similarities and differences between other developing countries

The strength of the course I also found, was hearing voices from other countries. My interest has been to understand the common challenges in many parts of the world, not India alone. This was an opportunity to hear how community health approaches have been used in other countries. The experience

** Food Sovereignty: A Right For All. Nyéléni 2007 - Forum for Food Sovereignty. 23rd - 27th February 2007. Sélingué. Mali. Can be accessed at: http://www.nyeleni.org/spip.php?article125

of how the PHM in the Philippines has been continually fighting the privatisation of healthcare and prevented the shutting down of particular government healthcare centres presents some of our common battles.

However it was also clear that each country has specific needs and the PHM plays varying degrees of importance in development efforts in health according to its capacity and level of establishment in that country.

- The human in environmental health

The presentations on environmental and occupational health were considerably different from discourses on environment I have heard before. Previously I felt environment was too strongly linked with ecology and lacked any human element to it. "Environment began to symbolise something out there" and I wasn't moved by an environment disconnected from human beings. Environmental health, as the presenters of the day conveyed was the very living space of human beings. These environmental spaces were redefined for me and I also understood its close link with occupational health.

Learnings of an intern presented through a chart

- Theory and practice working cyclically

The entire course drew on both theory and practice. (Recent) history of political and economic change, policy analysis, and ground realities were all interconnected. It seems like policy analysis can explain particular outcomes; and the communication of ground realities can in turn influence policy.

The course material too drew equally from theory and concepts, and showed how these theories have been interpreted and applied by communities. Sant's sharing of SATHI's experience is an example of this. His presentation showed how community based monitoring of government health services was applied through direct monitoring of health services, and in this case, forced a health system to function more accountably. Properly documented, these experiences have the potential to dent policy.

Additionally, through the IPHU course I understood the foundations of rights based approaches (RBA), as well as its uses. Previously in regards to RBA, I had seen theory and practice as mutually exclusive. Renu Khanna was very effective in explaining the ideology, as well as the applicability of the rights based approach. The Universal Declaration of Human Rights may be an ideal, but using the framework to identify and understand specific violations of human rights was very constructive.

- Future PHM activists- 3 areas of PHM, my future role

It was useful to understand the three forms the PHM broadly takes (or the paths it offers). First is an activist role with direct engagement with communities, campaigns and movements. The second is the role of a researcher, to gather new evidence to substantiate the principles of the PHM. The third is the IPHU itself. The way I understand it, the aim of IPHU is to foster young people to take one or more of these paths. Clearly, the purpose of the IPHU is to build a human resource base for the PHM.

With Amit Sen Gupta introducing the Global Health Watch and possibilities of contributing to it, this was the first time I considered research as a profession, as it shed light on how research too can be a form of activism.

- Self reflection: "You can't be part of the solution until you realise you're part of the problem"

This was a concept I really grappled with during the IPHU, mostly because I agreed with it to some degree. That "capital was accumulated by destroying people's health" is not a cross only governments ought to

bear, but 'privileged' citizens of the world too. Unfortunately, that induces a feeling more complex than guilt. To accept that I feed into and benefit from a system that is inequitable leaves me conflicted. This may not be a constructive feeling, but it is something I continue to understand, accommodate, make changes for and try to be at peace with.

- Bhavya Athmika Reddy

View from the Field

Experiences in Nandurbar

I spent a few days of my internship with the Lok Sangharsh Morcha who work in the Taloda and Akkalkua Talukas of Nandurbar, Maharashtra. Nandurbar is one of the districts of Maharashtra showing poor Human Development Index record and has been reporting the highest number of starvation/malnutrition deaths especially among children.

I came to know from the organization that the rate of malnutrition among the adivasis was quite low uptil the 1980s. This is probably because the forest and its products/resources were in the hands of the adivasis. More than 28 species of vegetables, roots and tubers were used by them from this forest wealth. But after Forest Reservation Act was passed in 1980 the problem of mal-nutrition started due to transfer of ownership and deforestation.

The remarkable work and perspective of Lok Sangharsh Morcha is well reflected in the book that came out as part of a study performed by them on malnutrition. This book, based on a true story is titled "This World is Living in Death" (english translation of the Marathi) based on a study by Pratibhatai Shinde, Smita Deshmukh & other group members of Loksamanvaya Pratishtan, Taloda.

This story begins with a small girl child named Pratibha, aged four months, who was suffering from third grade malnutrition. The child was admitted to the Dhadgaon taluk Primary Health Centre (PHC). However her condition worsened and the doctor referred her to the District hospital. Though the PHC is supposed to have a facility for transporting referred patients this PHC did not have an ambulance. As the family was not having that much of money to shift her up to District hospital, the father decided to bring Pratibha back to village. She died the same day. She died because of lack of proper support from the system and poverty. But on government record her death was recorded as having been due to meningitis. But even that did not record the root cause of the death which was malnutrition.

Lok Sangharsh Morcha came to know that in the year 1999 the number of child deaths reported in Taloda & Akkalkuva taluk were the highest in Maharashtra. In response to this the sanghatana sent a letter to District Health Officer inquiring about the deaths and their relation to malnutrition. This officer replied that as per government record these are not due to malnutrition but because of various infections and diseases. In this way he denied completely the presence of underlying malnutrition. Then the volunteers of this sanghatana started to study the real data by themselves taking the weight of children. They thus were able to document the falsification/under-reporting of malnutrition at the Anganwadi. It also came to their notice that the Anganwadi was reporting grade three and four malnourished children as being in grade one and two due to pressure from the supervisor. Volunteers then prepared a true list of malnourished children. From that list they come to know that the government has actually hidden nearly 90 percent of the malnutrition cases. The children who died were also malnourished children. But the government hospital denied this reason because on record the child was a healthy baby and its death was due to a particular disease. Then when the truth came in front of Sanghatana they started to record true status of the child and forced the Anganwadi to record their findings, they involved the community in this monitoring process. As well as they gave training to 25 community health workers and taught them necessary skills regarding to detection of malnutrition. When a fourth grade malnourished child is admitted to hospital by community health worker they started to check in which category the child is mentioned. Thus the hospital too could not deny the root cause as well as the true cause of death. This intensive study was submitted to the government as a report in 2005.

View from the Field

A sample table from the report is presented below:

Month		Grade III Children			Grade IV Children		
	Actual No. Of Children	Actual Data	Govt. Data	No. Of Children not in record	Actual Data	Govt. Data	No. Of Children Not in record
April	1089	127	14	113	61	6	55
May	1994	135	12	123	50	6	44
June	1148	104	17	87	35	3	32

My experience with the Lok Sangharsh Manch was very inspiring. I began to appreciate the influence the broader determinants of health like malnutrition and also its dependence on access to resources (which is especially so for adivasis). I also came to realize the importance of an alert community to monitor the actual recording of data and helping to know the root cause of illness. I also had a chance to understand the process of community mobilization, innovation, capacity building, impact and mass action and dialogues with the service providers and government officials.

- Tejaswini Balte

First Person

My journey in developing rural children as effective advocates

My journey in working with rural children took me to a new path, when I entered the community health learning programme. It transformed me to look at issues in the community in a new and broader perspective. After the orientation at CHLP, I set my interest to look at ways to understand issues of orphan and vulnerable children in the context of HIV and AIDS with active involvement of children themselves. So with support from the field volunteers I started my visit to each child's home and learnt from my exposure in the field that approaching children involves a different technique. We need to start from what they are interested in, into what foods they like and games they enjoy playing. This process helped me establish a better rapport, which was vivid from the way they addressed me initially as madam to akka (elder sister).

I would like to support this experience with one example of my visit to Karthik's house (name changed). My first visit was quite challenging as he was the first child I met in the field and he was quite reserved and restricted his responses to one word for every question I posed. This worried me deeply as it affected my confidence in working with children. Later not losing heart, and wanting to involve him in our support group, I followed him up over phone and again there was not much response or enthusiasm at his end. But I did not lose my interest and so invited him for the first support group meeting with other children in our center. He came but did not actively participate in the meeting. Later in the second meeting ,he started involving himself especially in sessions that involved narrating experiences with pictures and role play sessions .This was a major break through for him as well as for me as my confidence was built after seeing the change in him. I also started understanding the pressing issue that affected him from attending school. Before interacting with him, his parents expressed that he showed no interest in studies after knowing his HIV status, but later during the workshop sessions he had expressed his inability to concentrate as his friends tease him due to the physical changes that occur due to side effects of Anti-Retroviral (ARV). Now with the support group he has effectively coped with the challenge and is also an effective peer educator.

Working with children has helped me realize the diversified issues that affect them. Unless the affected population is involved the issue remains unaddressed. My brief exposure has helped me understand that children like to be involved and if provided a space where they are listened to and respected they are effective advocates for issues that affect them.

- Mary Julie

CHLP Batch 2009 along with CHC team

Creative Batch

North Karnataka Floods: The Aftermath

"We have lost everything. Food grains and household articles have been washed away in the floods. It is just God's mercy that we have survived," Somavva, a flood affected person from Raichur (DH, Oct 5, 2009).

On 1st October 2009 there was a sudden increase in water levels of Tungabhadra & Krishna rivers due to heavy rains in entire north Karnataka districts of Raichur, Koppal, Haveri, Bagalkote, Bijapur, Gulbarga, Bellary, Belgaum and Gadag. In just a matter of few hours, water entered to about 40 feet above road level in many villages along the rivers. These districts were just recovering from the severe drought this year and they had to face the onslaught of the floods as well.

Flooded Raichur District

Damage Caused

The entire rice crop was destroyed in the irrigated areas. Khariff crops - sugar cane, sunflower, tur dal, cotton jowar, bajra in thousands of acres in Bijapur, Indi, Sindagi, Basavan Bagewadi and Muddebihal taluks have been lost.

The villagers, whose houses have collapsed or submerged, are still camping at schools, temples and community halls. Farming and stone quarrying activities have come to a stand still, rendering thousands jobless. People residing along the banks of Krishna, Bhima and the Doni rivers were the worst affected. Many villages were cut off as most of the bridges were destroyed.

Flood Devastation at a glance

- 17.8 million people directly affected by the flood.
- One million people rendered homeless
- More than 3,55,000 people taken shelter in 1,211 relief camps in the worst-hit northern districts.
- More than 350 villages marooned; thousands stranded. Over 1.2 lakh houses collapsed.
- Death toll touches 175. Numbers still climbing.
- Over 3,000 animals washed away.
- 16 districts of Northern Karnataka affected

Source: AFP News, BBC News, Deccan Herald, Indian Express (Oct 05), Indian Express

Relief measures

The state government initiated immediate relief measures through the district level bodies. Government started distribution of rations and set up community kitchens (Ganji Kendras gruel centres), so that food can be prepared in the villages itself. Government also took help of helicopters to drop cooked food many villages which were still inaccessible by road. Government has also distributed lungis, sarees, blankets, to people living in the Ganji kendras and who had lost all their belongings. The government declared a compensation package for damaged houses Rs.37, 000 for severe damages and Rs.7, 000 for other damages.

Animal carcass seen after the flood waters receded

There was also significant civil society response through the relief efforts of various non-government organizations, the Red Cross, voluntary and philanthropic religious organizations in many of these districts. Various organisations have come together to share the responsibilities and resources to jointly meet the need in the affected districts. Networks like Jana Arogya Andolana Karnataka (JAAK, People's Health Movement Karnataka Chapter) with Headstreams, Community Health Cell (CHC) and Association for

People left homeless

India's Development (AID) spearheaded the relief measures focussing on identifying the most vulnerable, and those left out of the relief support. The immediate relief of food grains, blankets, oil and other household materials were also provided by JAAK in few villages. A core committee of JAAK members in the Northern Karnataka region was formed to strengthen the efforts of the People's health Movement in Karnataka.

People's Health Movement Response

- JAAK held a meeting on Oct 11, 2009 in Dharwad (North Karnataka) to take stock of things of the floods and to plan for the response meansures in which representatives of 11 districts from north Karnataka participated.
- The issue of discrimination to Dalits and the apathy shown by the government officers was reported. A resolution was passed to address these issues especially affecting the most vulnerable.
- JAAK partners concentrated on Bagalkote, Haveri and Raichur districts for immediate and longer term interventions.
- In Bagalkote district, the communities in Manneri, Kyada and Kitli villages of Historical Badami Taluka who were also submerged in the floods in 2007 and Dalits who were denied food in the flood situation were visited. Relief in terms of food grains, clothes, vessels is distributed. Similar efforts were done in 20 villages of Raichur district which were far away from the media reach.
- JAAK members have used the information on preventive measures of health and put pressure on the district administration for intervention.
- JAAK partners also have taken steps to verify the surveys done by the revenue officials, to alert on the discrepancies in the surveys conducted. Another step that was taken in Bagalkote and Raichur districts was to demand work under NREGA for the flood affected people.
- In Raichur district a cultural team has covered 35 villages as a psycho-social measure to bring people together and also facilitating people to air their grievances.

  The Kala-jatha teams are also raising awareness on health.

The extent of the damage caused by floods in the Raichur district

Health concerns

One of the major health concerns is the psychosocial stress of the devastation and the loss to life, property and livelihood. The National Institute of Medical and Neuro Sciences (NIMHANS) conducted training for relief workers on how to address the psychosocial stress of the flood affected people, especially women who have the burden of rebuilding the lives of their families.

The 60 slums in the Bijapur city had reported cases of H1N1 and dengue. While the chances of an epidemic outbreak are high in these areas as the sewage water was mixed with the flood water and haad entered all the houses. There was gross shortage of health assistants in Bijapur city, which has a population of three lakh. In Koppal, chikungunya, viral fever, diarrhoea was reported by people visiting the centre with complaints of fever and body ache.

Challenges of flood relief and rehabilitation

1) Improper compensation: There were lots of complaints regarding the assessment. In some villages the people were given compensation only for the houses whereas their granaries which had all the food grains, was also washed off in the rains. There is no proper way of assessing the damage. Corruption in giving compensation is also on the rise.

2) Equitable distribution of relief: The question of equitable and not equal distribution of relief was a real challenge. Some volunteers had gone to Kitli village of Badami taluk to distribute relief materials. They asked the community members to identify the households who needed the relief materials. A list of about 50 poorest households emerged, with most of them belonging to the Scheduled Caste (SC) communities. Soon a group of people from the 'upper castes' objected to the materials being given only to the poor SC households. They wanted the materials to be given to all the 350 households in the village. The fact that most of them had received relief materials in the earlier distribution, while the 50+ households had hardly received anything prior to this, did not cut any ice with the group. They wanted the volunteers to distribute the materials meant for another village which was badly affected. In the process some of the team members were man-handled and stopped from leaving. It took a lot of gentle persuasion and a firm stand to finally leave that village accomplishing what had been planned.

In Manneri village there were a group of people who had been twice displaced due to the floods. They had lost all their belongings twice in the span of three years. They lived at the end of the village in the hazardous places, just next to the river. Here too, the relief material was stopped by the 'upper caste' elders of the village who demanded that the relief materials be unloaded, so that they could decide about the distribution. Somehow the team managed to persuade the 'elders' and the materials were taken to the needy households. Later it was known that this was one of the few times when relief material had reached them after getting past the upper caste cordon of people.

The extent of the damage caused by floods in the Raichur district

3) Ganji kendra: The government has opened several ganji kendras but these need to exist till the situation has improved in some way. Also there needs to be an alternative to the rice gruel as staple diet of many affected people is Jowar and not rice. According to eyewitnesses, villagers who are used to the staple "Jowar Roti" were being given rice gruel, that too in limited quantities.

4) Poor administration: There is serious lack of intersectoral coordination and monitoring. The health and sanitation department needs to work hand in hand in curbing any imminent epidemics. With the unhygienic conditions left behind by the rain, the number is only expected to grow exponentially. In some places, the Municipal Corporation has only two fogging machines to fight against the growing number of mosquitos and other insects.

For four days, the villages of Hiresindogi, Chikkasindogi and Gunnalli were marooned in water. People were stranded in water for many hours. Yet, they did not have any drinking water.

Many places the government just responds to the people's protests. If one village protests, officers go there and respond, then other's and so on.

5) Health services: The government health system is not prepared to tackle the rise in disease cases and other preventive measures. For instance, there are no primary health centres or Anganwadis in Bijapur city, which should ideally have had at least 150 health assistants going by its population. There is a well-equipped district hospital, but with not enough doctors. While the actual requirement is for 33 doctors, there are only 15 doctors against the required number of 30 doctors. Of the 15 doctors, three are constantly at the emergency; two others are reserved for child delivery. The remaining 10 doctors have to cater to at least 900 patients on a daily basis.

The infrastructural facilities like water, electricity had collapsed. For example, the Community Health Centre staff in Koppal informed that basic amenities could not be offered to in-patients at the health centre, which is the only one in 19 villages. The Operation Theatre was closed for four days, as there was no power supply. For cases that came after dark, the doctors were forced to deliver babies in candlelight! "The Government has built a 40-bed hospital in the village. Soon, we will shift to the new building," the doctor said.

The problem of collapsed roads, bridges left patients to fend for themselves. Pregnant women couldn't cross the broken bridges to reach the nearest health centre. The Nurses and doctors found it difficult to visit their centres and the villages. One is doubtful whether regular supply of vaccines and immunization was possible in the immediate aftermath of the floods.

6) Larger apathy - Many villages and parts of some towns ,people had been twice displaced due to the floods. They had lost all their belongings twice in the span of three years. The need for psycho-social support is being felt, but has largely been unmet. The sources of livelihood for the affected people need to be explored.

Lessons to be learnt

- Due to the lack of coordination among relief measures, there was over-pouring of materials in some villages; the same villages which were given relief and which were accessible were visited repeatedly by various groups; this gave rise to sporadic tussle and conflicts among people vying for relief; old clothes were seen thrown on the roads as cultural sensitivity was not shown by the people who were giving clothes [e.g. jeans, short skirts and night gowns were given while the need was for cotton saries, bed-sheets, men's waist-clothes (dhotis), etc.]
- Not infrequently, though, there was not enough time for people to verify if the real needy got any one of those things. E.g. in Manneri village in Bagalkot district, even after two weeks, the Dalit community had not got any food relief, though several teams came and visited the village and the upper caste members took the responsibility of distributing materials.

- Naveen Thomas, E. Premdas, Pushpa Latha, R. Sukanya and Ruth Vivek

[CHC was involved in the districts of Raichur, Bellary and Haveri in the relief and rehabilitation initiatives. In the district of Haveri Mr. Karibasappa, CHLP alumni, took the intiative. Ms. Snehalatha, one of the CHLP interns spent her field placement during November and December 2009 with the flood affected people in Bagalkote district. Few of the interns were also involved in fund-raising activities for the flood-affected regions. They went to schools, colleges and offices making people aware of the magnitude of the disaster and encouraged contribution in cash and kind. - Ed.]

Editorial Desk

An overview of the Madhya Pradesh initiative

In early 2008 the CPHE Bangalore team and SOCHARA members dreamt of initiating a resource centre in MP, central India, which would run a Community Health fellowship program as a key strategy for its functioning. An idea draft of the dream received positive support from key stakeholders. A National Workshop in April 2008 in Bangalore discussed further the positioning of the initiative, the framework and curriculum. A preparatory phase starting in July 2008 included field visits and interactions with several NGOs, academic institutions and government officials across the state. A state level workshop in Bhopal in November 2008 helped to crystallise ideas into strategies. CPHE and the MP initiative were formally launched by SOCHARA at the silver jubilee celebration of the Community Health Cell (CHC) in Bangalore in December 2008. This seemed to flow organically from the initiation of the Community Health Fellowship Scheme in 2003 as a twentieth year initiative of CHC.

The Sir Dorabji Tata Trust and the Jamsetji Tata Trust provided a small grant and strategic inputs to the proposed plan, along with financial support from July 2009. This was in addition to funds already provided by the Sarathy Foundation. A hectic three months followed with finding and furnishing an office space in the home of Mr. and Mrs. Ramesh Kumar who provided invaluable help, establishing a six member

team and an eight member advisory committee. A group of twenty enthusiastic persons were selected from 74 applicants for the two year community health fellowship program. The first Advisory Committee meeting was held in Bhopal on 27th and 28th October 2009, and a meeting of the organisational heads of institutional partners met together on 29th October, followed by a simple and beautiful public launch. The teaching learning program for the first batch started on 1st Nov. 2009.

The initiative aims to contribute towards the goal of Health for All in Madhya Pradesh by training fellows on community action for health, by strengthening civil society and the public health system from below through research and policy advocacy with a focus on the National Rural Health Mission. The team and fellows with a network of institutional partners also hope to help address critical determinants of health particularly gender, under-nutrition and food insecurity, access to safe water and sanitation.

About the Resource Centre for Public Health-RCPH

The CPHE Bhopal office is consolidating and building on the experience of supporting public health policy processes and community action for health by SOCHARA in MP. These have included the response to the Bhopal Gas Disaster, the Rajiv Gandhi Health Missions, the Jan Swasthya Rakshak Programme evaluations, support to the Madhya Pradesh Human Development Report (see http//cphe.sochara.org) and active involvement in the second National Health Assembly of the Jan Swasthya Abhiyan in Bhopal in 2007. It also uses and builds on the approaches of SOCHARA, CHC and CPHE.

Presently the centre is facilitating the Madhya Pradesh Community Health Fellowship Programme (MP-CHFP) and developing a network for community health and public health. The evolving network has started with NGOs and others working with communities and the health system on health and development, with civil society organizations, peoples' movements and academics

About the Madhya Pradesh Community health fellowship Programme MP-CHFP

One of the objectives of SOCHARA is to evolve innovative educational programs in community health. Since its inception in 1984 (formally registered as SOCHARA in 1991), the CHC/SOCHARA team provided space, support, peer encouragement, vocational guidance and facilitation of self-study to young professionals in community health. The Centre for Public Health and Equity, is currently undertaking a two year Community Health Fellowship Program in Madhya Pradesh for 20 participants. This initiative is based, on the recommendations of the external reviews, and dissemination of the Community Health Fellowship Scheme idea and method which developed into the new programme "Community Health Fellowship Programme". The objectives of the CHFP are,

1. To establish a person centred Community Health Fellowship Program in Madhya Pradesh in 2009 with an intake of 20 young professionals per batch who become committed to community based health initiatives and processes over the period of their two-year course. To support them later in getting placements and providing opportunities for networking
2. To enable participants gain skills to build community capacity for health; to strengthen the public health system from below; and help develop strategies to reduce inequalities in health and access to health care, and
3. To develop and support practitioners, researchers and advocates in community health in Madhya Pradesh.
4. To develop a network of NGOs, academics and public health system staff keenly involved in community health action in Madhya Pradesh to undertake objective three & support objective two.
5. To develop the necessary organizational systems in Bhopal and Bangalore to support this, including a library and information unit focusing on health and health system issues relevant to central India, including developing a collection of resource material in Hindi

The Madhya Pradesh Community Health Fellowship Programme is a practitioner oriented, programme with conceptual and theoretical inputs along with adequate experiential learning. The programme takes professionals from multi-disciplinary backgrounds, for a period of two years, to learn and

work at a sub-district professionals from multi-disciplinary backgrounds, for a period of two years, to learn and work at a sub-district and district level. The participants of the programme will be involved in the strengthening the public health system from below by building community capacity for health and for effective participation in the health system utilizing mechanisms available under the National Rural Health Mission and other schemes.

Contact Details:
CPHE-SOCHARA Resource Centre for Public Health
E-8/74, Basant Kunj, Arera Colony
Bhopal-462039 Madhya Pradesh
Ph: 0755-2561511
Email: cphebhopal@sochara.org
Website: www.cphe.sochara.org

- Thelma Narayan and Deepak Kumaraswamy

An update on the CHC Initiative in Tamil Nadu

Over the last year the CHC team at Tamil Nadu has been involved in three major activities. One of the main activities has been the involvement with the Community Monitoring of Health Services Project under the NRHM; the other activity has been the involvement with the Makkal Nalavazhvu Iyakkam (MNI, the Tamil Nadu chapter of the People's Health Movement) and then the teaching and training activities.

The pilot phase of the Community Monitoring of Health Services and Planning project was completed in March 2009. Subsequently the CHC team based in Chennai has been lobbying with the Government of Tamil Nadu (GoTN) for an extension of the project and continued support to these processes over the coming years as well as the expansion of the idea to cover the whole of the state. As part of this the team was instrumental in evolving the concept in the Project implementation Plan of the GoTN, and was subsequently appointed by the government as the State Nodal NGO for the process. SOCHARA has subsequently signed a MoU with the GoTN for this project and the project has started from March 2010. It is planned that this huge process spread over nearly 450 panchayats in Tamil Nadu will provide a great learning opportunity for interns in the CHLP program.

Along with MNI, CHC (secretariat for MNI) was part of the process of evolving a plan of action for the next year where it is envisaged that the MNI will facilitate social audits all over the state in three areas that the Tamil Nadu government claims are its most significant health policies these are the immunization program, the encouragement of institutional deliveries and the insurance schemes. The MNI hopes to initiate a decentralized process of monitoring/auditing these schemes by the wide dissemination of background material and suggested formats for these audits.

Apart from these the team has been involved in teaching at the MPH program of the National Institute of Epidemiology, the Social work department of MOP Vaishnav College, Asian College of Journalism and Loyola College and for various NGOs and civil society groups. Members of the team have also provided support to numerous health related groups like the Tamil Nadu Health Development Forum, with their conferences, workshops etc. to bring to the fore the people's perspectives on health.

Contact Details:
Community Health Cell
No. 31, Prakasam Street
T. Nagar, Chennai - 600 017
Ph: 044 - 45502438

- Rakhal Gaitonde

Contributors for this Newsletter

Ms. Bhavya Athmika Reddy - CHLP Intern 2009 Batch
Dr. Deeksha Sharma - CHLP Intern 2009 Batch
Ms. Mary Julie - CHLP Intern 2009 Batch
Ms. Malavika Thirukode - CHLP Intern 2009 Batch
Ms. Shelly Dhar - CHLP Intern 2009 Batch
Mr. Shivakumar - CHLP Intern 2009 Batch
Ms. Tejaswini Balte - CHLP Intern 2009 Batch
Mr. Naveen Thomas - Headstreams (CHLP Alumni)
Dr. Thelma Narayan - Public Health Consultant, CPHE
Dr. Deepak Kumaraswamy - Research and Training Assistant, CPHE
Mr. E. Premdas - Coordinator, CHC
Dr. Rakhal Gaitonde - Training & Research Associate, CHC (Chennai)
Ms. Pushpa Latha - Admin & Secretarial Assistant, CHC
Dr. R. Sukanya - Research and Training Associate, CHC
Dr. Ruth Vivek - Training and Research Assistant, CHC

Editorial Team

Dr. R. Sukanya
Dr. Rakhal Gaitonde
Mr. E. Premdas
Dr. Ruth Vivek

Community Health Cell
A functional unit of the Society for Community Health Awareness, Research and Action (SOCHARA)
85/2, Ist Main, Maruthi Nagara, Madiwala,
Bengaluru - 560068
Tel/fax: +91-80-25531518/25525372
Email: chc@sochara.org
Website: www.sochara.org

The Community Health Learning Programme and this newsletter are currently supported by Sir Ratan Tata Trust (SRTT), Mumbai.